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ABSTRACT

Everytime an emergency telephone rings, the telephone worker may be faced with a life-threatening situation. An important decision facing the worker is whether to handle any given crisis call over the telephone, or to opt for a face-to-face contact. An inaccurate assessment or evaluation of a high-risk situation could contribute to serious consequences. Overreacting to what is actually a low-risk situation could result in the misuse of services and could create a dependency in the client. Emergency telephone staff are expected to make these critical assessments and evaluations without the benefit of physically viewing the patient or having control over his/her physical environment. Staff must rely totally on what they hear on the phone to evaluate, calm, motivate, plan and move the patient through the crisis toward stability. This decision-making process is examined and alternative strategies are considered in which factors such as risk assessment, resources, client responsiveness and articulateness, availability of staff, new vs. previous contact, and source of the request for contact are taken into account. (Author/JLL)

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TELEPHONE EVALUATIONS OF CRITICAL SITUATIONS

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Abstract

TELEPHONE EVALUATIONS OF CRITICAL SITUATIONS

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Everytime an emergency telephone rings - the telephone worker may be faced with a life-threatening situation. An important decision facing the worker is whether to handle any given crisis call over the telephone, or to opt for a face-to-face contact. The staff person knows that an inaccurate assessment or evaluation of a high risk situation could contribute to someone's life being seriously disrupted, or in some cases, ended. On the other hand, they know that overreacting to what is actually a low risk situation could not only result in the misuse of available services and the waste of community dollars, but could also create a dependency by the client on those services. Unlike mental health staff working in all other capacities, additional stress is on the emergency telephone staff because they are expected to make these critical assessments and evaluations without the benefit of physically viewing the patient or having control over his/her physical environment. Emergency telephone staff must rely totally on their voice and hearing to evaluate, calm, motivate, plan and move the patient through the crisis toward stability. This decision-making process is examined and alternative strategies are considered in which factors such as risk assessment, resources and client responsiveness are taken into account.

Every time an emergency mental health telephone rings, the telephone worker faces one of a wide variety of situations. The call may be a simple request for information; a lonely person just wanting to talk with someone; a family wanting help with a psychotic relative; a high risk, life threatening situation or any of a number of other problems. The telephone worker is faced with making many kinds of decisions in regard to handling each call. One of the primary decisions is whether or not an immediate face-to-face contact is necessary. This decision is made only after taking a variety of factors into account. This paper outlines those factors.

Although the Dane County Mental Health Center has a 24 hour per day capacity for immediate face-to-face contact, such involvement is not always viewed as positive. Because the most effective way to intervene in a crisis is to motivate the client to use his or her coping skills to their fullest capacity, providing a face-to-face contact can sometimes prevent the client from taking as much responsibility as that client is capable of handling. It can also create a false expectation of the emergency services offered. The client may, for example, expect a worker to see him or her immediately whenever they have a problem situation.

The Emergency Services Unit of the Dane County Mental Health Center offers both Emergency Telephone Services (ETS) and Crisis Intervention Services (CIS) on a 24-hour basis.

In addition, during the 8 a.m. to 5 p.m. work week, there is an emergency walk-in service which provides immediate access to a clinician for anyone presenting themselves at the Center as experiencing an emotional emergency. ETS is based in the Mental Health Center and answers some 1,000 calls a month in addition to seeing approximately 52 walk-ins per month. The Emergency Telephone Service is open to and advertised for use by individuals throughout the county who desire mental health services. CIS has a separate telephone number which is given solely to community agencies to use for requesting outreach crisis intervention services. Nine professional staff working rotating shifts respond on referral anywhere in the county. The emergency telephones are staffed by eight paraprofessionals who work full or part-time, also on rotating shifts. Typically there is one person answering the telephone at any given time. All agencies may make referrals to both ETS and CIS and these two services frequently refer to one another.

Given the capacity for a face-to-face contact through either the walk-in service or CIS, the telephone worker must make a decision on the most therapeutic means of attending to the caller. Unlike mental health staff working in most other capacities, additional stress is on the emergency telephone staff because they are expected to make these critical decisions and evaluations without the benefit of physically viewing the client or having control over his or her physical environment. Emergency telephone staff must

rely totally on their voice and hearing to decide, evaluate, calm, motivate, plan and move the caller through the crisis.

There are numerous factors to be considered in evaluating the need for a face-to-face contact. Some of these factors are weighted more heavily than others in making a final decision.

Risk Assessment: Risk assessment is the factor which is given highest priority. All aspects of risk assessment need to be explored carefully. This means determining a caller's suicide/homicide potential by quickly assessing such items as prior suicidal behavior, prior violent behavior, present plan, means available, length of time the plan has been considered and the affect behind the suicidal/homicidal ideation.

If a client's lethality is thought to be high, a face-to-face contact is usually appropriate. Such contact gives the caller reassurance that the worker's concern is genuine and the personal contact he or she may need in time of crisis. It also provides direction and structure for the client. The clinician benefits by gaining the opportunity to observe the client and, therefore, better evaluate the situation. Observing the affect of the caller, evaluating for signs of depression, and general physical appearance invariably contributes to a more accurate risk assessment. However, there are times when a client may refuse or be physically unable to come into the Mental Health Center. Again, if that client is thought to be a high suicide risk,

steps must be taken to move him or her through the crisis toward stability. In such cases, if the caller concurs, a home visit is usually considered appropriate.

Resources: Resources available to the caller are a factor which, when utilized appropriately, can prevent an unnecessary face-to-face contact. Identifying family and friends available to the caller and contacting them to provide support often lessens the need for an immediate professional, face-to-face contact. When the members of the support system can be mobilized to provide this immediate, in person contact, the telephone worker needs to remain available as consultant to them to shape their supportive efforts. This link also enables the worker to continue to monitor the crisis and evaluate the need for a clinical, face-to-face involvement.

If the caller's support system is non-existant, or if the significant others either cannot or will not provide the necessary assistance, a face-to-face involvement with staff will be arranged. This will also help to establish the emergency services unit as a future resource during crises and act as a support system for the client until other systems can be established.

Articulateness: Callers able to articulate their problems clearly are less likely to require a face-to-face contact. The verbal client can more frequently be counseled effectively over the telephone. If the client is vague and non-specific, a meeting may be indicated. The face-to-face contact in this instance allows the clinician to check the

client's affect, physical appearance and other non-verbal signals excluded by the telephone contact.

Time: The time spent with a caller can be a deciding factor in requesting a face-to-face contact. If the call has gone on for an hour or more and the emergency telephone worker feels that the seriousness of the risk has not decreased and the client has not moved significantly, getting the caller off the telephone and into the Mental Health Center could be enough to initiate some positive change for the caller. Indeed, by coming to the Center, the caller has taken a step toward de-escalation.

Another way of circumventing an impasse is for the worker to put down the telephone for a few minutes to consult with other staff. This provides input from others not as embroiled in the situation; and can result in a fresh approach by the telephone worker in dealing with the caller's problem. This also reinforces the worker's concern and desire to assist the caller in attaining the best possible resolution.

Availability of Staff: Availability of staff is an unavoidable factor in the decision-making process. If staff are involved with other calls or emergency walk-ins, the chances of seeing someone face to face rather than dealing with them by telephone decrease; unless, of course, it is a high risk situation. Time of day and agency policy are important factors in regard to staff availability. If a telephone worker is alone in the Mental Health Center, policy dictates that, to insure staff safety, no clients are

to be admitted to the building. In such situations, the telephone staff must either request other staff involvement or decide to maintain the caller over the telephone.

The volume of work on a given shift also affects staff physical and emotional availability. As business increases, the likelihood of a face-to-face contact decreases because of the probability of greater emotional depletion for staff during such contacts.

New vs. Previous Contact: It is important to discuss whether the client is a new caller or whether there has been previous contact with the caller. If it is a new caller, the worker has no previous experience to go on, however, if there has been previous contact, checking the records to see what treatment plan has worked previously can facilitate the decision-making process. Some of the things that would be considered are whether maintaining the caller over the telephone was successful, whether the caller had been seen previously face to face, and whether the caller is in an ongoing crisis situation.

Who's Making the Request: The emergency telephone worker does not always have control in opting for a face-to-face contact or deciding to maintain the caller over the telephone. Sometimes a referral comes in from another agency, particularly the police, who may bring a client directly to the Center before making any kind of telephone contact. With this kind of referral, the emergency worker will ask CIS to see the client. It is always important for the telephone worker to remember who is requesting the

contact (face-to-face or telephone) and to follow through appropriately. Sometimes a telephone worker may negotiate the request being made by another agency to see a client face to face because of past experience with that client. Such experience may indicate that the client has been previously maintained more successfully over the telephone than face to face. However, a request for a contact is always acted upon. Therefore, if a request for a face-to-face contact is overridden, the worker will be sure to contact the client by telephone.

The telephone worker must consider and review all of the above factors before making a therapeutic decision, one that allows the caller to exercise his or her coping skills to the fullest extent, while maintaining the direction and support of the worker. Obviously the more information available to the worker, the more accurate the decision. Also, it is important to keep in mind one's own bias when dealing with difficult clients. Consultation is the greatest safeguard against this pitfall. The decision-making process, therefore, should be a shared one whenever possible, thus insuring maximum benefit to the client and minimum burnout for the staff.

There is no real formula for the emergency telephone worker to learn. An ability to gain an overview of a situation and then make a decision based upon that view requires the ability to empathize with callers, an awareness of one's own fallibility and feelings, and experience with callers. Some of these attributes the telephone worker brings with

him or her. Others have to be acquired. Even with these attributes, however, success is often hard won when dealing with clients in crisis. Therefore, a sense of humor and a firm belief in one's own coping skills are essential.